STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525623	A. BUILDING **07** B. WING _____	**02/04/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY AT NU ROC HEALTH AND REHABILITATION CTR (THE)	**3576A NU ROC LN** **LAONA, WI 54541**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Survey was conducted by the Wisconsin Division of Quality Assurance on February 4, 2020. Bay at Nu Roc Health and Rehabilitation Ctr. was found to be in substantial compliance with the following applicable regulations for emergency preparedness: 42 CFR Subpart 483.73 - Emergency Preparedness For Long-Term Care (LTC) was MET Bay at Nu Roc Health and Rehabilitation Ctr. is a single story structure built in 1928, with Type V (000) construction. Healthcare additions were constructed in 1961, 1969, 1976, 1985, 1995, 2003, and 2006 with the same construction type. The facility was fully sprinkled and has smoke detection in all corridors. The facility had an emergency generator that provided power to the emergency loads. The facility contained 5 patient care wings and 12 smoke compartments. Bay at Nu Roc Health and Rehabilitation Ctr. was certified for 50 beds, with a census of 43 residents at the time of the survey. The facility was surveyed under the 42 CFR Subpart 483.73 for a Long term Care occupancy. No federal deficiencies of the Emergency Preparedness Code were cited.	E 000		
K 000	INITIAL COMMENTS A standard Recertification Survey for Life Safety Code compliance was conducted by the Wisconsin Division of Quality Assurance on February 4, 2020. Bay at Nu Roc Health and Rehabilitation Ctr. was found to NOT be in	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/21/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 substantial compliance with the following applicable regulations for long term care facility participation in Medicare-Medicaid: 42 CFR Subpart 483.90 - Physical Environment was NOT MET 42 CFR Subpart 483.90(a) - Safety from Fire was NOT MET NFPA 101 - Life Safety Code was NOT MET. Bay at Nu Roc Health and Rehabilitation Ctr is a single story structure built in 1928, with Type V (000) construction. Healthcare additions were constructed in 1961, 1969, 1976, 1985, 1995, 2003, and 2006 with the same construction type. The facility was fully sprinkled and has smoke detection in all corridors. The facility had an emergency generator that provided power to the emergency loads. The facility contained 5 patient care wings and 12 smoke compartments. Bay at Nu Roc Health and Rehabilitation Ctr is certified for 50 beds, with a census of 43 residents at the time of the survey. The facility was surveyed under the 2012 Life Safety Code, Chapter 19 for an existing health care occupancy. Four (4) federal deficiencies of the Life Safety Code were cited.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be	K 321		2/20/20

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K 321	Continued From page 2 separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide self-closing doors to provide a separation between hazardous areas and other spaces in accordance with NFPA 101 (2012 edition), Sections 19.3.21.2, 19.3.2.1.5(7), 8.4.3.5 and 7.2.1.8. These deficient practices could affect 12 of 43 residents and an undetermined number of staff and visitors. Findings include: 1. On 02/04/2020 at 12:25 pm, observation revealed that a room in the south end smoke compartment of Wing #4 near Social Services and Med Records was being used for storage of	K 321		

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K 321	Continued From page 3 combustible materials and the room was greater than 50 square feet with no door. The room was being used to store 8 wheelchairs, 2 folding walkers and a med cart. 2. On 02/04/2020 at 12:30 pm, observation revealed that a room labeled as Wheelchair Storage located at the north end of Wing #4 near Room #41 was being used for storage of combustible materials and the room was greater than 50 square feet. The room was being used to store 20 wheelchairs, 3 resident lifts and multiple folding walkers. The door was not equipped with a self-closer or automatic closing hardware. These deficient practices were confirmed by Staff A at the time of discovery.	K 321		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not conduct fire drills as required by NFPA 101 (2012 edition), 19.7.1.6., to ensure that staff	K 712		2/20/20

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K 712	Continued From page 4 are familiar with fire response procedures with fire drills that fully test the staff's ability to respond to fire emergencies. This deficiency had the potential to affect all 43 residents and an undetermined number of staff and visitors. Findings include: On 02/04/2020 at 11:15 am, record review revealed that the facility fire drill records were missing for the second and third shift during the third quarter of 2019. This deficient practice was confirmed by Staff A at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to inspect door assemblies at least annually, with written records of inspection and	K 761		2/20/20

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K 761	Continued From page 5 testing in accordance with NFPA 101(2012 edition), sections 19.7.6, 4.6.12, 7.2.1.15, 8.3.3. This deficient practice could affect all 43 residents and an undetermined number of staff and visitors. Findings include: On 02/04/2020 at 10:10 am, it was noted during record review that the facility had no documentation that fire/smoke door assemblies had been inspected or tested in the last year. This deficient practice was confirmed by Staff A at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		2/20/20

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K 914	Continued From page 6 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to test electrical receptacles in accordance with the requirements of NFPA 99 - 2012 edition, Section 6.3.3.2, 6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3 and 6.3.3.2.4. This deficient practice could affect all 43 residents and an undetermined number of staff and visitors. Findings include: On 02/04/2020 at 11:00 am, observation of non-hospital grade electrical outlets in resident rooms revealed that the facility had no documentation of the continuity of ground in circuit, polarity or retention testing of non-hospital grade resident room electrical outlets. This deficient practice was confirmed by Staff A at the time of discovery.	K 914		